OMB#: 0935-0104

PATIENT ID: **{HHRKUID}**

PROVIDER ID: **{PDDIRID}**

PROVIDER NAME: **{PROVNAME}**

FORM _____ OF _____

{FORMNUM} {FORMTOT}

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

HOSPITAL EVENT FORM

FOR

REFERENCE YEAR 2000

HOSPITAL EVENT FORM

[COMPLETE ONE FORM FOR EACH EVENT]

QUESTIONS A1 THROUGH A4: TO BE COMPLETED WITH MEDICAL RECORDS.

READ ONLY FOR FIRST EVENT FOR THIS PATIENT: (PATIENT NAME) reported that (he/she) received health care services from this facility during 2000.

MEDICAL RECORDS

A1. The (first/next) time (PATIENT NAME) received services during calendar year 2000, were the services received:

[CODE ONLY ONE]

As an Inpatient.....1 (A2a)
In a Hospital Outpatient Department.....2 (A2c)
In a Hospital Emergency Room or 3 (A2c)
Somewhere else? (Specify:) _____ 4 (A2c)
Long Term Care Unit (SNF, etc.) (Specify:)…….5 (A2a)
_____

Inpatient,
Outpatient,
Emergency Room,
Somewhere else,
Long Term Care
{MREVTYPE}
Somewhere else Specify, Text
{MREVTYOS}
Long Term Care Unit Specify, Text
{LTCUOS}

A2a. What were the admit and discharge dates of the (inpatient stay/stay)?

MO DAY YR
ADMIT: _____/ _____ /_____
DISCHARGE: _____/_____ /_____

Admit Date
{EVNTBEGM}
{EVNTBEGD}
{EVNTBEGY}
Discharge Date
{EVNTENDM}
{EVNTENDD}
{EVNTENDY}

A2b. Was (PATIENT NAME) admitted from the emergency room?

YES..... 1 (COMPLETE SEPARATE EVENT FORM FOR ER EVENT)
NO 2

Yes, No **{ADFROMER}**

GO TO A3

A2c. What was the date of this visit?

MO DAY YR
_____ / _____ / _____

Visit Date
{EVNTBEGM}
{EVNTBEGD}
{EVNTBEGY}

A3. Please give me the name, specialty and telephone number of each physician who provided services during the (TYPE OF EVENT) on (DATE(S)) and whose charges might not be included in the hospital bill. We want to include such doctors as radiologists, anesthesiologists, pathologists, and consulting specialists, but not residents, interns, or other doctors in training whose charges are included in the hospital bill.

[RECORD NAMES ON SEPARATELY BILLING DOCTOR FORM. IF RESPONDENT IS NOT SURE WHETHER A PARTICULAR DOCTOR'S CHARGES ARE INCLUDED IN THE HOSPITAL BILL, RECORD INFORMATION FOR THAT DOCTOR ON SEPARATELY BILLING DOCTOR FORM.]

SEPARATELY BILLING DOCTORS FOR THIS EVENT 1
NO SEPARATELY BILLING DOCTORS FOR THIS EVENT..... 2

Separately Billing Doctors,
No Separately Billing Doctors
{ANYSBDS}

A4a. I need the diagnoses for (this stay/this visit). I would prefer the ICD-9 codes (or DSM-IV codes), if they are available.

[IF CODES ARE NOT USED, RECORD DESCRIPTIONS.]

[IF THERE ARE MORE THAN 4 DIAGNOSES, USE A CONTINUATION SHEET.]

Check box {CKBX#}
Condition Code Number {ICDCND#}
Condition Description, Text {ICDPDS#}

	CODE	DESCRIPTION
|__|	_____	_____
|__|	_____	_____
|__|	_____	_____
|__|	_____	_____

\|__\|__\| OFFICE USE ONLY

A4b. Which of these was the principal diagnosis?

Principal Diagnosis {ICDPRIN}

IF ONLY ONE DIAGNOSIS, GO TO A4c.
IF MORE THAN ONE DIAGNOSIS:
- ■ CHECK BOX FOR PRINCIPAL DIAGNOSIS
- ■ CIRCLE '-8' IF PRINCIPAL DIAGNOSIS NOT KNOWN ..... -8

A4c. Have we covered all of this patient's events during the calendar year 2000?

Yes, all events covered,
No, need to cover additional events {ALLEVNTS}

YES, ALL EVENTS COVERED..... 1 (A4d)
NO, NEED TO COVER ADDITIONAL EVENTS ..... 2 (A1-NEXT EVENT FORM)

A4d. IF ALL EVENTS ARE RECORDED FOR THIS PATIENT, REVIEW NUMBER OF EVENTS REPORTED BY HOUSEHOLD.

NO DIFFERENCE OR FACILITY REPORTED MORE EVENTS THAN HOUSEHOLD..... 1 (ENDING FOR MEDICAL RECORDS)

FACILITY RECORDED FEWER VISITS 2

PROBE: (PATIENT NAME) reported (NUMBER) events at (FACILITY) during 2000, but I have only recorded (NUMBER) visits. Do you have any information in your records that would explain this discrepancy?

_____

_____

GO TO ENDING FOR MEDICAL RECORDS

ENDING FOR MEDICAL RECORDS:

GO TO NEXT PATIENT. IF NO MORE PATIENTS, THANK RESPONDENT AND END. THEN ATTEMPT CONTACT WITH PATIENT ACCOUNTS OR ADMINISTRATIVE OFFICE.

QUESTIONS A5a THROUGH END: TO BE COMPLETED WITH PATIENT ACCOUNTS.

READ ONLY FOR FIRST EVENT FOR THIS PATIENT: I have information from Medical Records that (PATIENT NAME) received health care services on [READ DATES OF ALL VISITS AND INPATIENT STAYS].

I'd like to ask you about the (visit on/stay which began on) [FIRST/NEXT DATE].

BOX 1
IF EVENT IS AN OUTPATIENT VISIT OR EMERGENCY ROOM VISIT OR SOMEWHERE ELSE (SEE A1), CONTINUE WITH A5a. IF EVENT IS AN INPATIENT STAY OR LONG TERM CARE UNIT (SEE A1), GO TO A8.

GLOBAL FEE

A5a. Was the visit on that date covered by a **global fee**, that is, was it included in a charge that covered services received on other dates as well?

[IF NECESSARY: *An example would be a patient who received a series of treatments, such as chemotherapy, that was covered by a single charge.*]

YES 1
NO 2 (A6a)

Yes, No **{GLOFEE}**

A5b. Did the global fee for this date cover any services received while the patient was an inpatient?

YES 1
NO 2 (A5d)

Yes, No **{GFEECOVS}**

A5c. What were the admit and discharge dates of that stay?

		MO	DAY	YR
Admit Date	**{GFEEBEGM} {GFEEBEGD} {GFEEBEGY}**	ADMIT:	_____/	_____/_____
Discharge Date	**{GFEEENDM} {GFEEENDD} {GFEEENDY}**	DISCHARGE:	_____/	_____/_____

A5d. What were the other dates on which services covered by this global fee were provided? Please include dates before or after 2000 if they were included in the global fee.

Other Dates of Service **{EVNTBEGM} {EVNTBEGD} {EVNTBEGY}**

Did (PATIENT NAME) receive the services on (DATE) in an:
Outpatient Department (TYPE=OP);
Emergency Room (TYPE=ER); or
Somewhere else (TYPE=96)?

MO DAY YR	TYPE	IF TYPE 96, SPECIFY:
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____

|__|__|
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Global Fee Type **{GFTYPE}**
Global Fee Type Specify, Text **{WHSPC}**

A5e. Do you expect (PATIENT NAME) will receive any future services that will be covered by this same global fee?

YES 1
NO 2

Yes, No **{GFEEFUTS}**

A6a. I need to know what services were provided during (this visit/these visits). I would prefer the CPT-4 codes, if they are available.

[IF CPT-4 CODES ARE NOT USED, RECORD DESCRIPTION OF SERVICES AND PROCEDURES PROVIDED.]

[IF THERE ARE MORE THAN 11 SERVICES, USE A CONTINUATION SHEET.]

CPT-4 Code Number **{MCPT#}**
Description of Services, Text **{MCPTDS#}**

A6b. ASK FOR EACH CPT-4 CODE OR DESCRIPTION: What was the **full established charge** for this service, before any adjustments or discounts?

[EXPLAIN IF NECESSARY: *The **full established charge** is the charge maintained in the hospital's master fee schedule for billing insurance carriers and Medicare or Medicaid. It is the "list price" for the service, before consideration of any discounts or adjustments resulting from contractual arrangements or agreements with insurance plans.*]

[IF NO CHARGE: *Some facilities that don't charge for each individual service do associate dollar amounts with services for purposes of budgeting or cost analysis. This is sometimes called a "**charge equivalent**." Could you give me the charge equivalents for these procedures*?]

Full Established Charge **{MCPTCH#}**

C2. IF NOT VOLUNTEERED, ASK: And what was the total? [IF NOT AVAILABLE, COMPUTE.]

Total Charges **{TOTLCHRG}**

C3. Was the facility reimbursed for (this visit/these visits) on a fee-for-service basis or capitated basis?

[EXPLAIN IF NECESSARY:]
***Fee-for-service** means that the facility was reimbursed on the basis of the services provided*.

***Capitated basis** means that the patient was enrolled in a prepaid managed care plan where reimbursement is not tied to specific visits.*

[INTERVIEWER: IF IN DOUBT, CODE FEE-FOR-SERVICE.]

Fee-for-Service Basis, Capitated Basis **{FEEORCAP}**

CPT-4 (including modifier)	Full established charge at time of visit or charge equivalent
a. _____	$_____._____
b. _____	$_____._____
c. _____	$_____._____
d. _____	$_____._____
e. _____	$_____._____
f. _____	$_____._____
g. _____	$_____._____
h. _____	$_____._____
i. _____	$_____._____
j. _____	$_____._____
k. _____	$_____._____

|__|__|
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TOTAL CHARGES **$_____._____**

FEE-FOR-SERVICE BASIS 1
CAPITATED BASIS..... 2 (C7a)

C4. From what sources has the facility received payment for (this visit/these visits) and how much was paid by each source?

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

INTERVIEWER: IF RESPONSE IS THE PATIENT PAYS A MONTHLY PREMIUM, GO BACK TO C3 AND CHANGE CODE TO 2 (CAPITATED BASIS).

Patient or Family	**{PATPAYM}**
Medicare	**{CAREPAYM}**
Medicaid	**{AIDPAYM}**
Private Insurance	**{PINSPAYM}**
VA	**{VAPAYM}**
TRICARE/CHAMPVA/CHAMPUS	**{CHAMPAYM}**
Worker's Comp	**{WORKPAYM}**
Other	**{OTHRPAYM}**
Other Specify, Text	**{OTPAYMOS}**

a. Patient or patient's family $_____.____

b. Medicare $_____.____

c. Medicaid $_____.____

d. Private Insurance $_____.____

e. VA $_____.____

f. TRICARE/CHAMPVA/ CHAMPUS $_____.____

g. Worker's Comp $_____.____

h. Other (Specify:)

_____ $_____.____

C5. IF NOT VOLUNTEERED, ASK: And what was the total? [IF NOT AVAILABLE, COMPUTE.]

Total Payments	**{TOTLPAYM}**

TOTAL PAYMENTS **$_____.__**

BOX 2
DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?
YES .....1 (BOX 3)
NO 2 (C6)

C6. It appears that the total payments were (less than/more than) the total charges. What is the reason for that difference? [CODE 1 (YES) FOR ALL REASONS MENTIONED.]

Adjustment or discount	
Medicare	**{DISCARE}**
Medicaid	**{DISCAID}**
Contractual arrangement	**{DISCNT}**
Courtesy discount	**{DISCRTS}**
Insurance write-off	**{DISINSU}**
Worker's Comp	**{DISWORK}**
Eligible veteran	**{ELIGVET}**
Other	**{DISOTH}**
Other Specify, Text	**{DISOTOS}**
Expecting additional payment	
Patient or Family	**{EPAYPAT}**
Medicare	**{EPAYCAR}**
Medicaid	**{EPAYAID}**
Private Insurance	**{EPAYPINS}**
VA	**{EPAYVA}**
TRICARE/CHAMPVA/CHAMPUS	**{EPAYCHAM}**
Worker's Comp	**{EPAYWORK}**
Other	**{EPAYOTH}**
Other Specify, Text	**{EPAYOTOS}**
Charity care or sliding scale	**{SLIDSCA}**
Bad debt	**{BADDEB}**
Payments more than charges	
Medicare	**{MORECARE}**
Medicaid	**{MORECAID}**
Private Insurance	**{MOREPINS}**
Other	**{PAYMOTH}**
Other Specify, Text	**{PAYMOTOS}**

PAYMENTS LESS THAN CHARGES:	YES	NO
Adjustment or discount		
a. Medicare limit or adjustment	1	2
b. Medicaid limit or adjustment	1	2
c. Contractual arrangement with insurer or managed care organization	1	2
d. Courtesy discount	1	2
e. Insurance write-off	1	2
f. Worker's Comp limit or adjustment	1	2
g. Eligible veteran	1	2
h. Other (Specify:)_____	1	2
Expecting additional payment		
i. Patient or Patient's Family	1	2
j. Medicare	1	2
k. Medicaid	1	2
l. Private Insurance	1	2
m. VA	1	2
n. TRICARE/CHAMPVA/CHAMPUS	1	2
o. Worker's Comp	1	2
p. Other (Specify:)_____	1	2
q. **Charity care or sliding scale**	1	2
r. **Bad debt**	1	2
PAYMENTS MORE THAN CHARGES:		
s. Medicare Adjustment	1	2
t. Medicaid Adjustment	1	2
u. Private insurance adjustment	1	2
v. Other (Specify:)_____	1	2

GO TO BOX 3

CAPITATED BASIS

C7a. What kind of insurance plan covered the patient for (this visit/these visits)? Was it:

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

		YES	NO
Medicare	**{COVCARE}**	1	2
Medicaid	**{COVAID}**	1	2
Private Insurance	**{COVPINS}**	1	2
VA	**{COVVA}**	1	2
TRICARE/CHAMPVA/CHAMPUS	**{COVCHAM}**	1	2
Worker's Comp	**{COVWORK}**	1	2
Something else	**{COVOTHR}**	1	2
Something else Specify, Text	**{COVOTOS}**		

C7b. Was there a co-payment for (this visit/these visits)?

Yes, No **{ANYCOPAY}**

YES 1
NO 2 (C7e)

C7c. How much was the co-payment?

Co-payment amount **{COPAYAMT}**

$_____.__

C7d. Who paid the co-payment?

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

		YES	NO
Patient or Family	**{CPAYPAT}**	1	2
Medicare	**{CPAYCARE}**	1	2
Medicaid	**{CPAYAID}**	1	2
Private Insurance	**{CPAYPINS}**	1	2
Other	**{CPAYOTHR}**	1	2
Other Specify, Text	**{CPAYOTOS}**		

C7e. Do your records show any other payments for (this visit/these visits)?

Yes, No **{OTHPAY}**

YES 1
NO ..... 2 (BOX 3)

C7f. From what other sources has the facility received payment for (this visit/these visits) and how much was paid by each source?

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

Patient or Family	**{OTHPAT}**	a. Patient or patient's family $_____.____
Medicare	**{OTHCARE}**	b. Medicare $_____.____
Medicaid	**{OTHAID}**	c. Medicaid $_____.____
Private Insurance	**{OTHPINS}**	d. Private Insurance $_____.____
VA	**{OTHVA}**	e. VA $_____.____
TRICARE/CHAMPVA/CHAMPUS	**{OTHCHAM}**	f. TRICARE/CHAMPVA/ CHAMPUS $_____.____
Worker's Comp	**{OTHWORK}**	g. Worker's Comp $_____.____
Other	**{OTHOTHR}**	h. Other (Specify:) _____ $_____.____
Other Specify, Text	**{OTHOTOS}**	

BOX 3 **{GOTORVIS}**

BOX 3
GLOBAL FEE SITUATION (A5a=YES) 1 (A11)
RECORDED 5 OR FEWER EVENTS 2 (A11)
RECORDED 6 OR MORE EVENTS 3 (A7a)

REPEATING IDENTICAL VISITS

A7a. Were there any other visits for this patient during 2000 for which the services and charges were identical to the services and charges for the visit on (DATE OF THIS EVENT)?

[EXPLAIN, IF NECESSARY: *We are referring here to **repeating identical visits**. These usually occur when the patient has a condition that requires very frequent visits, such as once- or twice-a-week physical therapy.*]

Yes, No **{OTHIDVIS}**

YES..... 1
NO..... 2 (A11)

A7b. During 2000 how many other visits were there for which the services and charges were identical to those on (DATE OF THIS EVENT)?

Number of Identical Visits **{VISNUM}**

OF VISITS_____

A7c. Please tell me the dates of those other visits.

[IF THERE WERE MORE THAN 30 IDENTICAL VISITS, USE A CONTINUATION SHEET.]

Other Identical Visit Dates **{EVNTBEGM}** **{EVNTBEGD}** **{EVNTBEGY}**

MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __

|__|__| OFFICE USE ONLY

GO TO A11

PATIENT ACCOUNTS QUESTIONS FOR INPATIENT.

A8. According to Medical Records, (PATIENT NAME) was an inpatient during the period from [DATE] to [DATE]. What was the DRG for this stay?

DRG: _____ (BOX 4)

DRG NOT RECORDED 1 (A9)

DRG **{STAYDRG}**
DRG not Recorded **{NODRG}**

A9. Did the patient have any surgical procedure during this stay?

YES 1
NO ..... 2 (BOX 4)

Yes, No **{ANYSURG}**

A10a. What surgical procedures were performed during this visit? Please give me the procedure codes, that is the CPT-4 codes, if they are available.

[IF CPT-4 CODES ARE NOT USED, RECORD DESCRIPTION OF SERVICES AND PROCEDURES PROVIDED.]

|__| _____
|__| _____
|__| _____
|__| _____

|__|__|
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Check box **{CHEKBX#}**
CPT-4 Code Number **{SRGCPT#}**
Surgical Description **{SRGDES#}**
Procedure Description **{SRGBET#}**

A10b. Which of these was the principal surgical procedure?

IF ONLY ONE PROCEDURE, GO TO BOX 4.
IF MORE THAN ONE PROCEDURE:
- CHECK BOX FOR PRINCIPAL PROCEDURE
- CIRCLE '-8' IF PRINCIPAL PROCEDURE NOT KNOWN..... -8

Principal Surgical Procedure **{SURGPRIN}**

BOX 4
ADMITTED FROM EMERGENCY ROOM
(A2b=YES)..... 1 (C2a)
OTHERWISE..... 2 (C2b)

C2a. What was the **full established charge** for this inpatient stay, before any adjustments or discounts? Please do not include any emergency room charges.

FULL ESTABLISHED CHARGE OR CHARGE EQUIVALENT:

$_____.____

C2b. What was the **full established charge** for this inpatient stay, before any adjustments or discounts?

[EXPLAIN IF NECESSARY: *The **full established charge** is the charge maintained in the hospital's master fee schedule for billing insurance carriers and Medicare or Medicaid. It is the "list price" for the service, before consideration of any discounts or adjustments resulting from contractual arrangements or agreements with insurance plans.*]

[IF NO CHARGE: *Some facilities that don't charge for each individual service do associate dollar amounts with services for purposes of budgeting or cost analysis. This is sometimes called a "**charge equivalent**." Could you give me the charge equivalent for this inpatient stay?*]

Full Established Charge {TOTLCHRG}
Emergency Room included,
Emergency Room not included {ERCHRINC}
Ancillary Charges included,
Ancillary Charges not included {ANCILL}

IF HS EVENT:
EMERGENCY ROOM CHARGE INCLUDED 1
EMERGENCY ROOM CHARGE NOT INCLUDED OR NOT APPLICABLE..... 2

IF IC EVENT:
ANCILLARY CHARGES INCLUDED..... 1
ANCILLARY CHARGES NOT INCLUDED OR NOT APPLICABLE..... 2

C3. Was the facility reimbursed for this inpatient stay on a fee-for-service basis or capitated basis?

[EXPLAIN IF NECESSARY:]
***Fee-for-service** means that the practice was reimbursed on the basis of the services provided*.

***Capitated basis** means that the patient was enrolled in a prepaid managed care plan where reimbursement is not tied to specific visits*.

[INTERVIEWER: IF IN DOUBT, CODE FEE-FOR-SERVICE.]

Fee-for-Service Basis,
Capitated Basis {FEEORCAP}

FEE-FOR-SERVICE BASIS 1
CAPITATED BASIS 2 (C7a)

C4. From what sources has the facility received payment for this stay and how much was paid by each source?

IF NAME OF INSURER, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

INTERVIEWER: IF RESPONSE IS THE PATIENT PAYS A MONTHLY PREMIUM, GO BACK TO C3 AND CHANGE CODE TO 2 (CAPITATED BASIS).

Patient or Family	**{PATPAYM}**
Medicare	**{CAREPAYM}**
Medicaid	**{AIDPAYM}**
Private Insurance	**{PINSPAYM}**
VA	**{VAPAYM}**
TRICARE/CHAMPVA/CHAMPUS	**{CHAMPAYM}**
Worker's Comp	**{WORKPAYM}**
Other	**{OTHRPAYM}**
Other Specify, Text	**{OTPAYMOS}**

a. Patient or patient's family $_____.____

b. Medicare $_____.____

c. Medicaid $_____.____

d. Private Insurance $_____.____

e. VA $_____.____

f. TRICARE/CHAMPVA/ CHAMPUS $_____.____

g. Worker's Comp $_____.____

h. Other (Specify:) _____ $_____.____

C5. IF NOT VOLUNTEERED, ASK: And what was the total? [IF NOT AVAILABLE, COMPUTE.]

Total Payments **{TOTLPAYM}**

TOTAL PAYMENTS **$_____.__**

BOX 5
DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?
YES 1 (A11)
NO 2 (C6)

C6. It appears that the total payments were (less than/more than) the total charges. What is the reason for that difference? [CODE 1 (YES) FOR ALL REASONS MENTIONED.]

Adjustment or discount	
Medicare	**{DISCARE}**
Medicaid	**{DISCAID}**
Contractual arrangement	**{DISCNT}**
Courtesy discount	**{DISCRTS}**
Insurance write-off	**{DISINSU}**
Worker's Comp	**{DISWORK}**
Eligible veteran	**{ELIGVET}**
Other	**{DISOTH}**
Other Specify, Text	**{DISOTOS}**
Expecting additional payment	
Patient or Family	**{EPAYPAT}**
Medicare	**{EPAYCAR}**
Medicaid	**{EPAYAID}**
Private Insurance	**{EPAYPINS}**
VA	**{EPAYVA}**
TRICARE/CHAMPVA/CHAMPUS	**{EPAYCHAM}**
Worker's Comp	**{EPAYWORK}**
Other	**{EPAYOTH}**
Other Specify, Text	**{EPAYOTOS}**
Charity care or sliding scale	**{SLIDSCA}**
Bad debt	**{BADDEB}**
Payments more than charges	
Medicare	**{MORECARE}**
Medicaid	**{MORECAID}**
Private Insurance	**{MOREPINS}**
Other	**{PAYMOTH}**
Other Specify, Text	**{PAYMOTOS}**

PAYMENTS LESS THAN CHARGES:	YES	NO
Adjustment or discount		
a. Medicare limit or adjustment	1	2
b. Medicaid limit or adjustment	1	2
c. Contractual arrangement with insurer or managed care organization	1	2
d. Courtesy discount	1	2
e. Insurance write-off	1	2
f. Worker's Comp limit or adjustment	1	2
g. Eligible veteran	1	2
h. Other (Specify:)_____	1	2
Expecting additional payment		
i. Patient or Patient's Family	1	2
j. Medicare	1	2
k. Medicaid	1	2
l. Private Insurance	1	2
m. VA	1	2
n. TRICARE/CHAMPVA/CHAMPUS	1	2
o. Worker's Comp	1	2
p. Other (Specify:)_____	1	2
q. **Charity care or sliding scale**	1	2
r. **Bad debt**	1	2
PAYMENTS MORE THAN CHARGES:		
s. Medicare Adjustment	1	2
t. Medicaid Adjustment	1	2
u. Private insurance adjustment	1	2
v. Other (Specify:)_____	1	2

GO TO A11

CAPITATED BASIS

C7a. What kind of insurance plan covered the patient for (this visit/these visits)? Was it:

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

		YES	NO
a. Medicare	{COVCARE}	1	2
b. Medicaid	{COVAID}	1	2
c. Private Insurance	{COVPINS}	1	2
d. VA	{COVVA}	1	2
e. TRICARE/CHAMPVA/CHAMPUS	{COVCHAM}	1	2
f. Worker's Comp or	{COVWORK}	1	2
g. Something else? (Specify:) _____	{COVOTHR}	1	2
Something else Specify, Text	{COVOTOS}		

C7b. Was there a co-payment for (this visit/these visits)?

YES	1	
NO	2	(C7e)
Yes, No	**{ANYCOPAY}**	

C7c. How much was the co-payment?

$_____.__

Co-payment amount {COPAYAMT}

C7d. Who paid the co-payment?

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

		YES	NO
a. Patient or patient's family	{CPAYPAT}	1	2
b. Medicare	{CPAYCARE}	1	2
c. Medicaid	{CPAYAID}	1	2
d. Private Insurance	{CPAYPINS}	1	2
e. Other (Specify:) _____	{CPAYOTHR}	1	2
Other Specify, Text	{CPAYOTOS}		

C7e. Do your records show any other payments for (this visit/these visits)?

YES	1	
NO	2	(A11)
Yes, No	**{OTHPAY}**	

C7f. From what other sources has the facility received payment for (this visit/these visits) and how much was paid by each source?

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

a. Patient or patient's family	$_____.____	{OTHPAT}
b. Medicare	$_____.____	{OTHCARE}
c. Medicaid	$_____.____	{OTHAID}
d. Private Insurance	$_____.____	{OTHPINS}
e. VA	$_____.____	{OTHVA}
f. TRICARE/CHAMPVA/ CHAMPUS	$_____.____	{OTHCHAM}
g. Worker's Comp	$_____.____	{OTHWORK}
h. Other (Specify:) _____	$_____.____	{OTHOTHR}
Other Specify, Text		{OTHOTOS}

A11. ARE THERE ANY ADDITIONAL EVENTS FOR THIS PATIENT TO BE ACCOUNTED FOR?

YES	1	(GO TO PATIENT ACCOUNTS SECTION (A5a) OF NEXT EVENT FORM.)
NO	2	(GO TO NEXT PATIENT. IF NO MORE PATIENTS, THANK RESPONDENT AND END.)